# Sustaining Change in Healthcare: Four Steps to Simplifying Improvement


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# Executive Summary

In the two decades since the Institute of Medicine released the historic report, *To Err is Human,* healthcare professionals have worked diligently to improve the quality and safety of patient care. A tremendous amount of work went into implementing Core Measures, National Patient Safety Goals, Disease-Specific Certifications, and Electronic Medical Records. We have applied the Studer Model, Shared Governance models, and Just Culture to provide structure to our improvement efforts. We created Patient Experience Officers and departments to improve HCAHPS scores. We hired Lean consultants who taught us how to identify the root cause, eliminate waste in our systems, and reduce variability using Six Sigma. But despite this dedicated effort over the past 20 years, healthcare error remains the third leading cause of death in the United States, [1] and we continually rank last among the other 10 wealthiest countries in the world in overall healthcare quality. [2]

So, why is this? As hard as we have all worked to improve quality, safety, and service in healthcare organizations, why haven't we been more effective? Why do healthcare leaders across the country continue to lament that their hard-won improvements are not sustained over time? And why are our clinicians burning out at unprecedented rates?

At Prosser Solutions, we think the answer is **complexity**. Healthcare leaders have all had the best of intentions since we began focusing more on safety and quality over the past 20 years, but in most organizations, we created layer upon layer of improvement that has resulted in an *extremely* complex care environment. Over time, the *process of improvement itself* has become much more difficult than it needs to be.

So, what is the key to sustaining change? *Simplify your improvement systems*.

Simplification can be accomplished by following these four critical steps:

1. Eliminate the silos among your improvement teams
2. Focus on the patient, not the metric
3. Make it easy for the frontline to know what to do
4. Empower leaders to effectively manage change

In this paper, we will share some tips about how you can implement each of these steps in your organization. Following this approach will result in improved quality and safety metrics, increased patient satisfaction, and reduced clinician burnout, *all at the same time*, leading to better financial outcomes. Of course, as is true for any significant culture change, this work *must* be actively supported by the Board of Governors (BOG) and led by the Executive Team if it is to be successful. This work takes commitment by leaders at all levels of the organization.

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*The key to sustaining change? Simplify your improvement systems.*

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# Step One:

# Eliminate the Silos Among Your Improvement Teams

Our focus on enhancing patient outcomes and eliminating unintentional harm was always well-intended, but our many competing priorities combined with the appropriate sense of urgency we have all felt has resulted in a "patchwork quilt" of improvement in most organizations.

Think about how this occurred: each time a new best practice or regulatory requirement emerged, we created a new committee or improvement team. We embraced Lean as a method to hardwire our change efforts because we recognized that eliminating waste is key to implementing a successful continuous improvement system, and a core component of this philosophy is to involve the people who do the work in improving the work. So, executives appropriately empowered the frontline and department managers to apply these principles in their own areas.

Although necessary, this added to the layering of improvement that was already occurring. In most organizations, this has effectively resulted in a system where *the right hand doesn't know what the left hand is improving.* The problem with this is that the *accumulation* of all this improvement creates an extremely complex care environment where clinicians are barely treading water.

Here's an example of a typical scenario in a hospital:

- Risk Management implements a practice change due to a recent serious safety event or lawsuit
- The Quality Department rolls out new protocols for Core Measures
- The IT Department releases a new upgrade to the EMR
- Unit-level improvement teams implement changes to improve falls and pressure ulcers

All of this happens at the same time, with the improvement teams working in silos and unaware of what each other is implementing. New queries are *added* to the EMR rather than

*incorporated* into existing or other new documentation, and the frontline becomes inundated with several changes at once. Generally, patients have more than one problem, so this approach can often create double or even triple documentation for a single patient. It's no wonder that our clinicians are burning out at unprecedented rates.

So, how do we fix this?

## Two Strategies to Eliminate the Silos Among Your Improvement Teams

1. Develop a clear understanding of what is happening around improvement in your organization.
   Start by identifying how many committees and improvement teams you have. This can often be difficult to uncover, because with so many departments and project teams working in silos, there is generally no global understanding of everything that is happening and how the accumulation of each team's efforts will affect the frontline. Once you begin to dive deep into this, you will be amazed at how many groups are meeting, and often discussing the same things.

   Next, identify what each team is doing. Committees generally function in three different ways:
   a. analyze data and determine problems
   b. plan and implement a process or practice change
   c. report results and celebrate

   Committees should try to avoid doing all of these at the same time, because duplication of efforts often occurs when committees who are supposed to be reporting begin analyzing and proposing new solutions. This can quickly result in disengagement of the implementation team members if they perceive that their work is a waste of time.

   Once you have a grasp on how many committees and project teams you have and what they are doing, measure the wasted productivity:

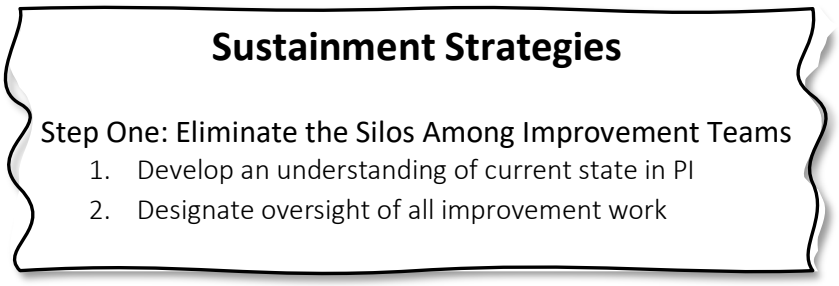
   **# meeting hours x # attendees x average hourly rate = total cost**

   Then break down how much of the total cost is due to duplication of efforts. That amount represents wasted, precious dollars for your organization.

2. **Designate a person, committee, or department to oversee all of the change that is happening across the organization.**

   This does not mean that the frontline should not be involved in creating change, or that we take the responsibility and accountability for change away from the project teams. It can be as simple as creating a calendar that tracks the expected changes and implementation timelines from *all* improvement teams. This will prevent rolling out numerous changes all at once and allows you to more thoughtfully schedule project implementation. It also provides an opportunity to see whether the process or documentation changes proposed by various teams could be combined to be more efficient.

   Consider looking to some of your existing committees, such as the Quality Council or your Nursing Leadership Team, to manage this. If they are only in the business of *reporting*, and they are allowing the improvement teams to analyze and implement interventions, then they should have the bandwidth to manage this oversight. Transparency and a strong communication process are critical to the success of this model, and as with any transformative process, these efforts *must* be supported by the BOG and the Senior Executive Team or it will fail.



# Step Two:

# Focus on the Patient, Not the Metric

Metrics are important, and the mantra, "What gets measured gets improved" is absolutely accurate. Clinicians know this, because they are trained in the scientific method and measurement has always been an inherent part of their work. But in most organizations, we created improvement teams *specifically* to address a particular metric or set of metrics, rather than in response to patient needs.

This began when Core Measures were introduced in 2001, when we were faced with the reality that the public reporting of our outcomes would become a requirement within a few short years. As new Core Measures, IHI collaboratives, disease-specific certifications, and HCAHPS were introduced, we layered on even more improvement teams, focused specifically on the metrics that each program required us to improve. Hence, the overwhelming number of committees and project teams we discussed in Step One.

Most organizations today have a mission, vision, or service statement that says that patient and family-centered care is a core value, but our reality is that care remains much more clinician-centered than patient-centered. Although there has been a tremendous focus on the patient experience in the past 10 years, it is not the same thing as patient-centered care. A true culture that focuses on the needs of the patient and family must be embedded into *every* level of the organization, *including your improvement system.*

## Two Strategies to Focus on the Patient, Not the Metric

1. Complete an organization-wide assessment of your current patient and family-centered care culture.

   There are a few tools available online that can help you with this, and one of the best is from the Institute for Healthcare Improvement. It's free and can be easily found at:

http://www.ihi.org/resources/Pages/Tools/PatientFamilyCenteredCareOrganizationalSelfAssessmentTool.aspx

This tool will walk you through an assessment of all levels of your organization and helps you to quantify where you are on a scale from 1-5. The IHI recommends that you complete this assessment with various groups, from patient advisors and the frontline, to your physicians and executive teams. Generally, it's quite eye-opening to see the difference in how these groups each perceive how patient-centered the culture really is.

2. Think holistically about your improvement structure.

Consider combining your improvement teams so that they focus on similar patient populations. It may be easier to visualize this if you think about the stakeholders that need to be involved. For example, identify all of the teams in your organization that are focused on some problem or disease-process related to either oxygenation or ventilation, such as COPD, pneumonia, influenza, and mechanical ventilation. It's likely that you have nursing, infection control, pulmonologists, respiratory therapy, and someone from quality and IT, among others on each of your teams.

Combining their efforts into a single group focused on all of these patient populations can reduce the number of meetings they are required to attend, making your improvement work more efficient, interdisciplinary, and less costly. Although this approach is simpler, it's not always easy, because even though everyone is generally in agreement that there are too many committees and that efforts should be better aligned, they also think that the teams that should be eliminated belong to everyone else but them. Getting buy in on this approach from every leader is critical, and as is true for each of these four steps, this work must be driven by the BOG and the Executive Team.

**Sustainment Strategies**

Step Two: Focus on the Patient, Not the Metric

1. Complete an organization wide PFCC self-assessment
2. Think holistically about improvement

# Step Three:

# Make It Easy for the Frontline to Know What to Do

Every organization has different documents, resources, and references that guide clinical practice. We don't all call them the same thing, but they essentially fall into 6 categories, which we call *the 6Ps of Practice.*

**The 6Ps of Practice**:

1. Practice Guidelines
2. Policies & Procedures
3. Protocols & Order Sets
4. Patient Education Material
5. Patient Care Documentation
6. Professional Development

How many *thousands* of such references do you have in your organization? Can the frontline easily locate them?

Chances are, if your organization is like most, the number is overwhelming, and your frontline clinicians likely don't even know that many of them exist. Even though most hospitals have adopted electronic policy and procedure management systems, searching for specific documents and guidelines is rarely easy. None of the systems on the market have the algorithmic power of Google, so when you search for a key word you get every document that has that word in it. Most people won't work that hard to find out this information and so they rely on the collective knowledge of the team to know what to do. Unfortunately, this knowledge is not always accurate, and so organizational expectations are not followed.

## Two Strategies to Make It Easier for the Frontline to Know What to Do

1. 5S your 6Ps

   Many of you will recognize that 5S is a lean term, but if you are not familiar with lean terminology, this essentially means to organize these documents and references. As with each of the four steps, this begins with an assessment of where you are. The easiest way to do this is to follow the same holistic approach that we discussed in step two and focus on patient populations. Improvement teams should ask themselves:

   **When caring for a patient with "X" problem (i.e., CHF, AMI, Stroke, etc.), how many of the 6Ps are there that guide care practices across the entire organization?**

   Once each team has identified all of the documents and references relevant to a given population, have them ask themselves the following questions:

   - Are they all consistent and evidence-based?
   - Are there multiple documents that conflict with each other?
   - Are your policies easily understandable, or are they written in regulatory or legal language that is confusing to the people who need to use them?
   - Are all of your protocols built into your EMR or are some embedded in a policy somewhere?
   - Are there clear expectations of which patient education materials should be used, and are they easily accessible?
   - Are your "documentation tip sheets" so many pages that clinicians just ignore them?
   - How many different computer-based learning modules do your clinicians have to complete, and how often is the content replicated or inconsistent in other modules, because they are written by different authors?

   If each team analyzes the current state by examining all the related documents and references in addition to identifying process steps, they will begin to get a picture of how complex the care environment has become. Then the teams can work to combine, clarify, or eliminate as many of these references as possible. Consider developing a standardized checklist for your improvement

teams, so that moving forward, all process change takes any of the related 6Ps into consideration.

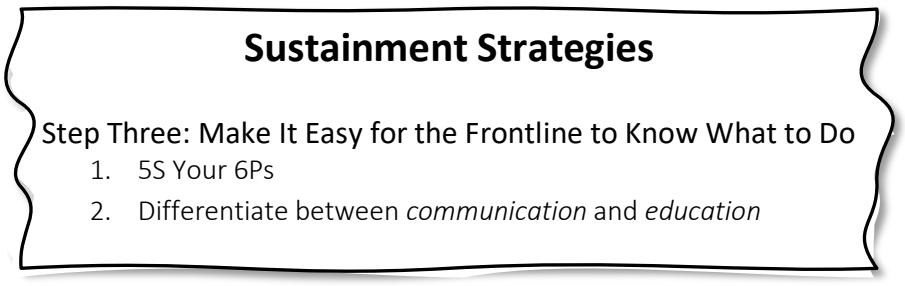
2. Clarify the difference between communication and education in your organization.

   These are not the same thing, and very often, improvement teams think that education is the answer to everything. But unless you are truly trying to change behavior, then you just need to communicate, not educate.

   Develop a consistent, standardized process for both of these tactics. If you are communicating, make sure that everyone is in agreement about how information is disseminated. You might use newsletters, huddle boards, intranet communication, and so on. The important thing is that the communication methods are *consistent*, so that the frontline can easily find it and know what's expected of them.

   Create a standardized process for education. Start with a focus on the needs of adult learners, who typically don't respond well to Power Point modules. Then, establish a curriculum that begins with orientation, consistently follows through to competency validation and can be modified to include necessary ongoing continuing education. Layering on computer-based modules doesn't make learning happen. It just makes clinicians crazy and encourages them to cheat.

   And as with all of the steps, BOG and Executive Team support and leadership are critical.



# Step Four:

# Empower Your Leaders to Effectively Manage Change

Healthcare leadership can be very challenging, because there are so many competing priorities. There are also numerous urgent and emergent issues that continually need to be addressed, such as nurse staffing: many managers report spending up to half of their day getting the right complement of staff for upcoming shifts. While this is a necessary and critical component of hospital operations, these managers often struggle to complete their other tasks, like budgeting, ordering supplies, recruiting new staff, completing evaluations, and so on. Add to this the need for them to manage the constant change that defines healthcare today, and you can begin to understand why the nurse manager role is often hard to fill.

Most senior executives today have come to understand the importance of empowering frontline leaders to hold their teams accountable and implement improvement in their departments, but the sad reality is that there are unreasonable workload expectations that make it almost impossible for anyone but the high performers to effectively manage change. Since only 20% of leaders in any organization are truly high performers, middle performers often struggle to keep up and do not feel empowered. We have to make it easier for them to be successful.

## Two Strategies to Empower Leaders to Effectively Manager Change

1. Lighten their load.

   Just as we discussed in the first three steps, start with an assessment of the tasks and responsibilities that are required of your leaders. Most executives who do a deep dive like this are very surprised to learn about show much time their leaders waste filling out forms, getting multiple signature approvals, tracking down staff who haven't completed their computer learning modules, and so much more.

Once you have a handle on what your leaders are really spending their time doing, apply your lean thinking to their workload.

- What can be eliminated all together?
- What processes can be streamlined to become more efficient?
- What tasks can be taken on by an upcoming leader as part of a structured succession plan?

2. Align your leader competencies with your leadership development program.

Ensure that your organization has a clear set of *measurable* competencies for each leader and that their ongoing performance is evaluated based upon these skills and abilities. Once a year is not enough for a young leader to understand what their learning needs are so they can be provided with the opportunities they need to improve.

Next, examine your leadership development program. How much of this education time is spent sitting in a chair in a classroom or through the completion of online learning modules? High level adult learners like your leaders need to be able to *apply* knowledge, not just absorb it. So, consider including creative opportunities into your leadership programs, like shadowing other leaders, interviewing executives, attending board meetings, and role playing with their peers.

Empowering your leaders is about much more than just telling them they have the power. If you can simplify their workload and structure leadership development based upon adult learning principles, you will get a much stronger leadership team that is able to more effectively sustain change. Again, it can't be emphasized enough that this work begin at the BOG and Executive Team level.

**Sustainment Strategies**

Step Four: Empower Your Leaders to Effectively Manage Change

1. Lighten their load
2. Align leader competencies with development plans

# Summary

Following the **Four Steps to Simplifying Improvement** requires an organizational commitment, driven by the Board of Governors and the Senior Executive Team. Taking this holistic approach is a bold, innovative solution that is not easy, but it *is* transformative. If you eliminate the silos, focus on the patient, make it easy for clinicians to know the expectations, and empower your leaders, you will find that you are able to improve and sustain *all* of your scorecard goals.

We hope that have found this information to be useful. Please let us know if we can help you to apply this knowledge in your organization. Our experienced lean improvement facilitators at Prosser Solutions can help you to complete assessments, develop improvement plans, and guide your teams through implementation and evaluation.

We are also available to provide interactive team-based education and one-on-one coaching. You can schedule a call through our website, www.ProsserSolutions.com, to learn more about how we can help you make care safer, better, and more efficient in your organization.

**Sustainment Strategies**

Step One: Eliminate the Silos Among Improvement Teams

1. Develop an understanding of current state in PI
2. Designate oversight of all improvement work

Step Two: Focus on the Patient, Not the Metric

1. Complete an organization wide PFCC self-assessment
2. Think holistically about improvement

Step Three: Make It Easy for the Frontline to Know What to Do

1. 5S Your 6Ps
2. Differentiate between *communication* and *education*

Step Four: Empower Your Leaders to Effectively Manage Change

1. Lighten their load
2. Align leader competencies with development plans

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